



Please circle: Mr. Mrs. Ms. Miss Dr.

Name: _____ Date: _____
Last, First, Middle initial

Home Address: _____ City: _____ State: _____ Zip: _____

Telephone: _____
Home Cell Work

Birth Date: _____ Age: _____ SSN: _____ Email Address: _____

Health Insurance Carrier: _____ Guarantor: _____

Relationship to Guarantor: _____ Guarantor Date of Birth: _____

Secondary Insurance Carrier: _____ Guarantor: _____

Relationship to Guarantor: _____ Guarantor Date of Birth: _____

Communications

May we leave appointment confirmations/cancellations via your home phone, cell phone or work phone? Y N

May we leave negative (benign) test results on your home phone answering machine or cell phone? Y N

If unreachable via telephone may we send you correspondence via mail? Y N

May we contact other medical offices for reports? Y N

Our office will file insurance for all reimbursable services, to both your primary and secondary insurance carriers. Please remember that you are responsible for all deductible, co-pay, and non-covered service amounts. See our complete financial policy for details.

Patient Release

I certify that the information that I have provided is correct. I authorize the release of medical information necessary to process insurance claims to insurance companies or their agencies (including Medicare) for purpose of filing and payment of medical claims. I authorize payment of medical benefits to the provider.

I certify that I hereby authorize SOMA Skin & Laser, its providers and staff to provide my minor child in my absence with examinations and basic treatment for which additional consents are not required. I understand as the legal guardian of this child I am required to be physically present to consult with the provider on any procedures which require separate consent such as surgery, biopsy, or wart destructions. I understand additional written consent may be necessary for these type of procedures and that the legal guardian must be present for such consent.

Signature _____ Date: _____